September 17, 2003

Re: MDR # M2-03-1627-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic Surgery.

Clinical History:
This 37-year-old female sustained a work-related injury to her neck and low back on ___. She had extensive treatment, with all the pain medications, physical therapy, TENS unit, chiropractic manipulations, work hardening, MRI's and x-rays, complaining of ongoing neck and back pain.

The patient has a concurrent history of rheumatoid arthritis, Sjorgen's syndrome, fibromyalgia, hypertension, depression, migraine headaches and anemia. The MRI of the lumbar spine and cervical spine was said to be unremarkable.

Disputed Service:
Chronic behavioral pain management, five times per week for six weeks.

Decision:
The reviewer agrees with the determination of the insurance carrier. The services in question are not medically necessary in this case.

Rationale:
The injury is a cervical and lumbar strain/sprain without objective evidence of pathology. The patient does have many personal co-morbid medical problems. The medical providers diagnosis of cervical and lumbar strain, as reported by the objective MRI imaging studies, confirms the diagnosis. There is no generally accepted indication for the intensity of care that she is receiving, in particular, for the chronic pain program that is requested, for a diagnosis of cervical and lumbar sprain.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or

other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on September 17, 2003.

Sincerely,